What's required to overcome big insurers and achieve real healthcare relief for employers and working families?

In Massachusetts, an innovative group of employers, doctors and entrepreneurs are pulling together today's best ideas and eliminating the single biggest obstacle to better care.

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PART ONE

A sick heathcare system: How did we get here?

INTRODUCTION

Powerful stakeholders. Unshakeable alliances.

The first employer-sponsored health plans were popularized to help attract employees in the competitive decade after WWII—but only after a form of universal coverage was proposed by Harry Truman—and immediately denounced by entrenched interests like the American Hospital Association, the American Medical Association, and the U.S. Chamber of Commerce.

Backed by nearly bottomless funding from insurance companies and the pharmaceutical industry, there are few higher-stakes games in state and federal capitols than the lobbying surrounding healthcare's $4.1 trillion[1] annual bounty.

Lobbyists representing insurers, big pharma, provider advocates, labor unions, employer groups, IT vendors, and other vested interests are advancing various—often directly competing—outcomes and interests, none of which is the greatest public good or genuine relief for ordinary citizens. In fact, if the ultimate influence goes to the deepest pockets, as it almost certainly does, it's not likely that patients, employers, (or even providers) will ever find meaningful relief, until public servants take up their cause in earnest.

Fortunately, there are now proven ways forward that are both effective and practical—approaches that "connect the dots" and make progress along multiple axes.

To answer why more progress isn't being quickly made, a closer look at today's entrenched pitfalls can be instructive—and an overview of the impact will confirm why patients and employers alike are desperate for relief.

[1] CMS.gov

Can we really expect insurance companies to fix the broken healthcare system they created?

An expensive, inefficient, needlessly complicated system.

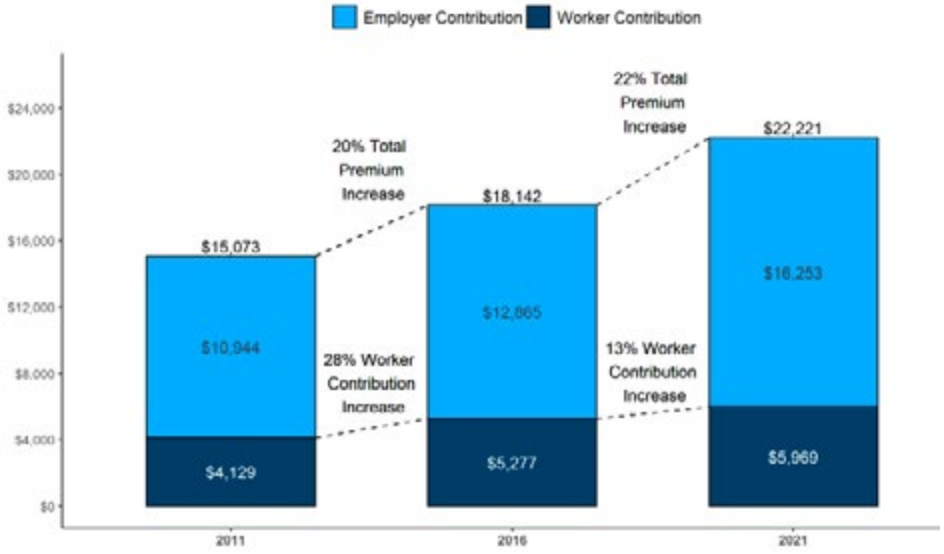
It's not working for patients

Fear of out-of-pocket costs actually keeps 25% of all American from seeking the care they need. And half of us avoid needed treatment simply because we're confused about what services are covered by our insurer gatekeepers.[2] This situation is dangerous for patients, frustrating for doctors, and often leads to more expensive outcomes when people don't maintain their health.

It's not working for employers

For the last three decades (and longer) employers have borne the brunt of healthcare cost increases. They have endured year-over-year increases that outpaced any other business expense. Compelled by law and/or the need to attract workers, they have watched annual healthcare premium rise to $22,221 per worker family, of which they pay $16,252. The increases have been untenable—and are now at crisis level.

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2011, 2016, and 2021



SOURCE: KFF Employer Health Benefits Survey, 2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011 and 2016

It's not working for providers

The status quo no longer serves the healthcare profession either, with restrictive contracts, obstructive interference in treatment, and arbitrary reimbursement policies that have actually lowered the quality of life for physicians.[3] To understand how nonsensical the system is, you only have to look at the range of reimbursements—completely disconnected from both the cost of providing services—or the efficacy of their outcomes:

> *One of the major contributing factors to rising health care costs is unnecessary and wasteful spending, as evidenced by the significant variation in the amount that hospitals and physicians are paid by private insurers for essentially the same service. These payment variations reveal waste, which is an important driver of spending in health care markets across the US.*[4]

[2]Kaiser Family Foundation survey
[3]CHG Healthcare Survey, 2002 "Why So Many Doctors Are Quitting" (advisory.com)
[4]Slusky, R. "Reducing Payment Variation In Private-Sector Health Care Markets" HealthAffairs 5-8-19

Massachusetts families are struggling in three ways...

HIGHER HEALTHCARE PREMIUMS

Family health insurance premiums grew approximately $500 in 2020 to nearly $22,000 per year including employer and employee premium contributions.

MORE SERVICES REQUIRED

Increased pandemic-related hardships including COVID-19-related illness, hospitalization and death, loss of employment and income, exacerbation of mental health problems including anxiety and depression, and overall decline in well-being.

DISPROPORTIONATE IMPACT

These hardships were particularly pronounced among residents with low to medium levels of income ($50,000-$99,000), half of whom reported difficulty paying household expenses (52.2 percent) and symptoms of depression (49.9 percent) and anxiety (52.8 percent) in August of 2020 – all representing far higher rates than for residents with higher incomes.

Data from Massachusetts 2022 Health Care Cost Trends

Times are changing: Information is the new power.

According to Beckers, the healthcare lobby spent $690 million, in 2021 to influence state and federal policymakers. This is big insurance and big pharma doing everything they can to hang on to a high-stakes game that is thoroughly weighted in their favor.

How telling is it, then, that even in the face of this investment, modest but meaningful action is finally being taken that opposes some of these entrenched interests. For example:

The healthcare lobby spent $690 million, in 2021 to influence state and federal policymakers.

- The new Centers for Medicare & Medicaid Services ("CMS") rules around insurer transparency (July, 2022) building on the previous rules for hospital chargemasters
- Healthcare provisions within the pending Inflation Reduction Act (August, 2022) Including potential caps on out-of-pocket costs for insulin and the ability for Medicare to negotiate prescription drug prices

It's encouraging to think that actions like these signal a new opening for evidence-based innovation in healthcare that can overcome long-standing systemic roadblocks.

To help drive further, meaningful, permanent, change, it may be helpful to understand the underlying power structure of today's healthcare landscape.

The power structure of today's sick healthcare system

INSURERS

- Determine what services are covered
- Set reimbursement rates for doctors and other providers
- Increase premiums to employers even in the face of record profits

PROVIDERS

- Succumb to take-it-or-leave-it reimbursement policies
- Endure second-guessing and gatekeeping by non-clinicians
- Juggle unprecedented patient volumes (zero work-life balance)
- Reluctantly participate in "sick-care system" (income tied to treatments)

EMPLOYERS

- Mandated to provide coverage
- Need to offer attractive benefits to compete for workers
- Few options to escape annual increases from "usual suspects"
- Administering self-funded plans time consuming/distracting from business

Power Level = Strong
They set the rules.
They reap the profits.

Power Level = Compromised
Constrained by bureaucrats.
Limited financial autonomy.

Power Level = Negligible
Little choice but to renew traditional options that don't answer needs or satisfy employees.

Four historical obstacles to meaningful change in employer-sponsored health benefits:

Of course, we're not the first generation to try to create alternative solutions to the insurer-driven system. As one example:

The Fallon Clinic was named for its founder, Dr. John Fallon. The clinic, the health plan and St. Vincent Hospital in Worcester once formed the Fallon Healthcare System, which offered patients insurance, access to doctors and hospital care.

In 1996, the system began coming apart. The former OrNda HealthCorp acquired the hospital and a stake in the clinic. The hospital's ownership later changed two more times, and investors shed their stake in the clinic in 2005. The clinic and health plan cut their ties in 2004.[5]

5 Worcester Telegram & Gazette, 7-7-2011

Historically, “new” health benefits schemes have failed due to four dynamics that (until now) have proven insurmountable:

1. "New ideas" from the same vested interests.

Like the robber-barons of the early 20th century, relying on insurers or big pharma to regulate themselves is a "fox guarding the hen house" prospect. Solutions that have been proposed from these sources usually begin with a presumption that holding onto record profits is the first order of business. Even as governments begin to implement reforms, big insurance coalitions (sometimes referred to as "BUCA" for Blue Cross/Blue Shield, United Health, Cigna, and Aetna) are busy finding workarounds and promoting programs that some industry insiders term "fake savings."

2. Perverse incentives for providers.

Smart doctors want to (and ought to) be paid accordingly. Instead, the system is rigged to encourage physician and hospitals to game the system. For years, healthcare reformers, have pointed to the fee-for-service model as an intrinsic obstacle to better care, writing in 2015:

> "There appears to be a general consensus that Fee-for-Service payment is an evil practice leading to overprovision, inefficiency and uncontrollable health expenditures. The assumption is that FFS encourages physicians to deliver more and unnecessary services to maximize their income." [6]

3. The margin of mystery.

While new transparency regulations show great promise in furthering consumerism in healthcare, there are still many opportunities for vested interests to build-in hidden mechanisms for revenue grabs. That’s why price transparency must be paired with better access to meaningful information:

State and federal policymakers are leveraging health care price transparency as a potential strategy to curb rising health care costs… The theory is essentially “knowledge is power”—if a patient has sufficient understanding of the costs for a health service prior to receiving care, they can seek high quality services at the lowest cost. […] [However,] consumers may struggle to shop for health services due to the complex nature of the health care system. Without corresponding quality data that is easy to interpret, patients often default to the highest cost provider even though health care quality is often not correlated with price. Even with accurate price information for a particular procedure, patients may be responsible for other costs—such as facility fees or subsequent prescriptions following the procedure or service.[7]

4. There's no profit in healthy people.

Under today's system, revenue is tied to the delivery of medical services. Virtually every clinician will extol the value of diet and exercise, so how come there is still so little interest (or action) in proven methods for keeping people healthier? Perhaps, as one poster to a healthcare forum candidly put it: "There is no profit in keeping people healthy and disease free. The profit is in treating ailments and diseases. As long as there is no profit in keeping people healthy, the motivation remains to let people get sick before they are of value."

Under the current structure, then, it is simply a matter of pointing out "the Emperor has no clothes." So what can—realistically and affordably—be done about it?[8]

6 Ikegami, N. Int J Health Policy Management, February 2015
7 Transparency and Disclosure of Health Care Prices, National Conference of State Legislatures, 9-7-21
8 Dibble, T., Quora thread regarding Alphabet (Google)’s now-aborted attempt to move into healthcare

Part Two
New possibilities are coming together

The current confluence of big data, shifting public opinion/awareness, provider openness to innovation, and a re-commitment to patient-centered education and interventions provides a new, and more promising opportunity, for some much-needed change.

A feisty group of altruistic doctors and industry "turncoats" are successfully executing a whole new approach—today at AllaraCare.

It began with one Massachusetts doctor and an entrepreneur who believed that a primary-care centered approach, under a system that eliminated all of the contracted complexity imposed by health insurers could better use the expenditures of employers and employees alike, while addressing the desire to pay providers fairly for keeping people healthy—instead of tying their incentives to performing procedures and tests.

Mark's ideas soon drew attention from other industry professionals who were fed up with how far "health care" had strayed from its original purpose and mission.

"We knew we had to start over and go back to the fundamentals while working within the confines of the current system created by the large insurance companies, going back to the doctor patient relationship as the key element to get people health and keep them healthy.

"This starts by helping consumers of health care know where to get the help they need with transparency on quality and cost[1], bringing back the value equation to healthcare, no hidden secrets."

—Dr. Mark Allara

AllaraCare has proven popular with its members, its provider network and employer partners.

[1] According to a 2021 Mercer survey of employers, health benefit cost jumped 6.3% in 2021, and although employers expect a more typical increase of 4.4% in 2022, a number of factors: higher utilization due to "catch-up" care, claims for long COVID, new extremely high-cost cellular drug therapies, and overall inflation in health care prices, could very well result in ongoing cost growth acceleration projected above 5% in 2023.

Connecting the Dots

The real cure for our broken system will bring ALL the best ideas into play.

The AllaraCare model brings together a powerful combination of many single-focused innovations of the past 20 years into a comprehensive and cohesive model that allows all stakeholders—employers, providers, and patients—to make important changes right now.

This model can be thought of as a "crawl-walk-run" approach to the extensive transformation required to cure this mammoth problem.

AllaraCare believes they are pulling together all required elements as they:

Innovate by restructuring and emphasizing primary care/wellness

- Spreading the word to employers that new plans are available, grounded in common sense and fair play—and powered by new attitudes and technologies
- Using an array of proven tools to deliver "high-value care" including individualized patient health coaching, incentives to stay healthy—and the support to make it happen
- Recapturing and redirecting the extensive revenue now lost to insurers (upwards of 40% of each healthcare dollar), using it, instead for actual care delivery, and returning the remaining savings to the people who pay for the coverage (i.e., employers and their workers.)

Innovate by optimizing the way health information is shared

- Operating from the core principle that people should be free to make their own choices about the care they want
- Finding a way to provide people with clear, unbiased information about the costs and value of the doctors, hospitals, and labs they visit, so they can compare & understand their options
- Giving people all the tools and encouragement they need to stay healthy—along with a share in the financial savings of those health-smart behaviors.

Innovate by simplifying the way healthcare is compensated

- Giving healthcare providers fair pay for quality care
- Providing direct compensation to doctors with no insurance middleman
- Helping employers pay a stable rate that reflects their population/usage
- Including an insurance element that guards against catastrophic expenses for employers

The bottom-line impact of freedom and choice...

AllaraCare believes this altruism will pay off in the end, in an equitable and sustainable system that gets back to what fair-minded providers like Dr. Sidney Garfield (Kaiser Foundation) set out to do in the 1930s. A system that lets doctors and nurses care for patients again. And a system that restores trust in what used to be an unshakable faith between healthcare professionals and their patients.

Part Three
The way forward...

The four essential elements required to heal the sick healthcare system:

1 Reining-in runaway costs

Start with employers and their workers who are seeing year-over-year increases with no rise in quality. It shouldn't be wrong to examine the VALUE of our care. And it's IMPERATIVE to look at where each healthcare dollar is being spent.

2 Guided consumerism vs. mere transparency

Recent price transparency mandates are a great start, but people also need access to smart and unbiased help in understanding their options. And not simply old-insurance gatekeepers in new guises. There is great opportunity in connecting people with trusted sources (e.g. nurses) to help them make healthier decisions that can impact the whole system.

3 Focus on "high-value" care

High-value health care is a broadly defined term, but the essential component is this: Is the spend worth the outcome—to the patient and to the employer who bears (or shares) the cost of the care? Academic and professional organizations are beginning to identify six key components of high-value care: a clear, shared vision with the patient at the center; leadership and professionalism of health care workers; a robust IT infrastructure; broad access to care; and payment models that reward quality improvement over volume. By honestly examining these elements—and applying unbiased modern data analysis—it will be possible to make important improvements.

4 Fiduciary alignment

This is most-often the big one. As noted above, yesterday's solutions have all come from parties who have a vested interest in the status quo. Real change can't occur when 40% of the healthcare dollar is still being squandered by insurance administration and lost to fraud and waste. The fact is, there is real savings in keeping people healthy. Successful approaches will ensure that this savings is passed along to patients and employers—and not viewed as more potential for runaway profiteering.

The final indispensable ingredient: TRUST

With all of the factors cited in this article, it's no surprise that ordinary people (patients and employers alike) are skeptical of anyone promising to "help them" with their healthcare. And no shock. So much of today's patient-facing infrastructure is designed to gatekeep. Out of pocket charges are manipulated by insurers to discourage people from seeking expensive care. Confusing (if not downright arbitrary) prior authorization restrictions tie the hands of both patients and doctors. And even after care takes place, insurers reserve the right to renegotiate the terms—or avoid paying altogether with adjudication and re-pricing schemes.

Central to the nurturing of trust is clarity of intention and real transparency of execution.

People trust nurses. That why programs any solution that is sincere about creating healthier populations must give them the power to make the right decisions—not simply the cheapest ones (or the ones that are most profitable.) AllaraCare, for example, maintains a corps of healthcare guides (called "A+ Navigators") whose explicit charge is to help members navigate their healthcare plan and find optimal, high-value care for every encounter.

Here's an example of what that looked like in an emergency situation for a member who was traveling out-of-state:

> *"While on vacation, I sustained an injury late in the day. I texted my A+ Navigator via the app inquiring where I could go that would be covered under my plan. Within minutes I had a message back, asking if I was OK. She also asked the zip code of our vacation spot. Within minutes, I had a list of five facilities within a few miles that could handle my injury. She also provided the cost of the visit for each place."*

People still trust their physicians, too—which is why health plans need to be working to put more of the decision-making back into their hands. Direct-pay models not only eliminate unproductive gatekeeping and second-guessing, they allow return a sense of agency and self-direction that today's physicians will insist upon to maintain the work-life balance they've earned.

In short, the challenges in changing such an entrenched and influential industry are significant, but not impossible. The terrain is better known than ever, and significant research has uncovered the location of significant waste and inefficiency. The good news is that earnest, well-intentioned entities are emerging, armed with the insight, technology, and wherewithal to make a real difference—as their vision is shared and joined. ▫

SUMMARY

In 2022-23, the spotlight will be squarely on healthcare. Three things employers, providers, and policymakers can do to shine...

1. Understand why solutions from vested interests may be intrinsically suspect
2. Give a fair hearing to new solutions that give employers, employees, & families real options These options can produce win-win-win results without unduly disrupting current policies.
3. Amplify the efforts of professionals committed to truly changing our broken system

To learn more about how you can join the next-generation of true healthcare change, schedule an informative presentation that goes into greater details about the AllaraCare difference: sales@allaracare.com.